STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155729	A. BUILDING 01 B. WING	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HERITAGE	12011 WHITTERN RD MONROEVILLE, IN 46773

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/11/14 Facility Number: 002549 Provider Number: 155729 AIM Number: 200289420 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Adams Heritage was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, areas open to corridor and hard wired smoke detectors in the resident rooms. The facility has a capacity of 61	K010000	Preparation and execution of this plan of correction does not constitute admission or agreement by provider to the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. adams-Heritage maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, adams-Heritage asserts that it is in substantial compliance with regulations governing the operation of long term care facilities, and this Plan of Correction in its entirety constitutes this provider's allegation of compliance and, thereby, we request resurvey to verify such as of September 26, 2014. **Further, we request desk review (paper compliance) for compliance, if acceptable.** Completion dates are provided for procedural processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated accomplished corrective action. These do not necessarily	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	and had a census of 52 at the time of this survey. All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered were a detached shed used for storage of maintenance equipment, parts and the facility's bus. Another detached shed used for storage of maintenance supplies. Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/15/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:		chronologically correspond to the date that Adams Heritage is under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.	
K010025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling	K010025	K025	09/13/2014

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	smoke barriers was maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect facility staff. Findings include: Based on an observation with the Maintenance Supervisor on 09/11/14 at 11:55 a.m., there were two unsealed three quarter inch ceiling penetrations in the electrical area of the main mechanical room. Measurements were provided by the Maintenance Supervisor at the time of observation. 3.1-19(b)		***1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice?*** Mechanical room is always locked. Both penetrations were sealed immediately. ***2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** None identified. Mechanical room is always locked. And both penetrations were sealed immediately.. ***3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** Monthly environmental rounds are performed to make sure all penetration are identified and corrected. ***4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?*** Information gathered from the audits will be forwarded to the QA committee for recommendations and review monthly for two months, then quarterly	

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			thereafter. QA committee will recommend that we continue the environmental rounds on a monthly basis. ***5. By what date the systemic changes will be completed?*** September 13, 2014	
K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door for 1 of 1 Prairie Path shower rooms, used to store soiled linen therefore creating a hazardous area, would self close and latched into the door frame. This deficient practice could affect 1 of 5 smoke compartments. Findings include: Based on an observation with the Administrator and the Maintenance Supervisor on 09/11/14 at 11:40 a.m., the	K010029	K029 ***1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice?*** The door closer was replaced to repair the latch. ***2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** Other residents that could be	09/13/2014

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	corridor door to the Prairie Path Shower room, containing 8 trash bags full of soiled linen, did self close but failed to latch into the door frame. At the time of observation, the Maintenance Supervisor acknowledged the Prairie Path shower room was used to store soiled linen. 3.1-19(b)		affected by the same deficient practice would be identified as those shower doors that does not latch. None were so identified. ***3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** Monthly environmental rounds will performed by Maintainence supervisor and Administrator bi-weekly for two months, then monthly thereafter to ensure the shower doors latch appropriately. ***4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?*** Information gathered from the audits will be forwarded to the QA committee for recommendations and review monthly for two months, then quarterly thereafter. QA committee will recommend that we continue the environmental rounds on a monthly basis. ***5. By what date the systemic changes will be completed?*** September 13, 2014	
K010038	NFPA 101			

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SS=E	LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress from 1 of 5 exits was readily accessible for instant use in the event of fire. LSC Section 19-2, Means of Egress Requirements, requires every exit discharge, exit location and access shall be in accordance with LSC Chapter 7. LSC 7.1.10, Means of Egress Reliability, requires the means of egress be maintained free of impediments to full instant use in case of fire or other emergency. Additionally, LSC Section 4.6.10 allows buildings or portions of buildings to be occupied during construction, repair, alterations, or additions only if all required means of egress and all required fire protection features are in place and continuously maintained for the portion occupied. This deficient practice affects 1 of 5 smoke compartments. Findings include: Based on observation with the Administrator and the Maintenance Supervisor on 09/11/14 at 11:08 a.m., exit signs in the main lobby were illuminated directing all occupants to use the main entrance in the event of an	K010038	K038 ***1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice?*** Signs were covered with black poster board. ***2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** Other residents that could be affected by the same deficient practice would be identified as those exit signs not covered during construction. None were so identified. ***3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** Future construction will be closely monitor to ensure Exit signs are covered by doors were construction Is affecting the entrance. ***4. How the corrective action(s)***	09/13/2014

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	emergency. Based on an interview with the Maintenance Supervisor at the time of observation, a new canopy is under construction at the main entrance and this entrance/exit is not being used during construction therefore the exit signs should be removed or covered to avoid confusion. 3.1-19(b)		***will be monitored to ensure the deficient practice will not recur?*** Information gathered from the audits will be forwarded to the QA committee for recommendations and review monthly for two months, then quarterly thereafter. QA committee will recommend time frame for continuing monitoring. ***5. By what date the systemic changes will be completed?*** September 13, 2014	
K010046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and interview, the facility failed to ensure 2 of 5 battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice could affect residents near the main lobby and in Heritage Hall. Findings include: Based on observation and interview with Maintenance Supervisor on 09/11/14 at 11:07 a.m. and then again at 12:20 p.m.,	K010046	K046 ***1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice?*** Battery replaced in main lobby emergency light and exit door light in Heritage hall. ***2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** Other residents that could be affected by the same deficient practice would be	09/13/2014

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	he acknowledged the battery operated emergency lights in the main lobby and near the exit door in Heritage hall failed to illuminate when tested. 3.1-19(b)		identified as those exit door lights or emergency lights not working. None were so identified. ***3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** Monthly environmental rounds will performed by Maintainence supervisor and Administrator to ensure the exit lights and emergency lights are working. ***4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?*** Information gathered from the audits will be forwarded to the QA committee for recommendations and review monthly for two months, then quarterly thereafter. QA committee will recommend that we continue the environmental rounds on a monthly basis. ***5. By what date the systemic changes will be completed?*** September 13, 2014	
K010062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating			

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	condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review and interview, the facility failed to ensure 1 of 1 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected and the necessary corrective action shall be taken. This deficient practice could affect all staff, visitors and residents. Findings include: Based on record review and interview with the Maintenance Supervisor on 09/11/14 at 10:25 a.m., the last annual inspection for the private fire hydrant on the facility's property was 08/27/13. Based on an interview with the Maintenance Supervisor at the time of record review, he is aware of the previous inspection date and has contacted the inspection company for an annual inspection. 3.1-19(b)	K010062	K062 ***1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice?*** Hydrant was inspected by VFP Systems, Fort Wayne, IN ***2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** Other residents that could be affected by the same deficient practice would be identified as those hydrant not being inspected yearly. None were so identified. ***3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** Monitor dates of previous inspection closely. Call 2 months in advance. ***4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?*** Information gathered from the	09/18/2014

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			audits will be forwarded to the QA committee for recommendations and review monthly for two months, then quarterly thereafter. QA committee will recommend time frame for continuing monitoring. ***5. By what date the systemic changes will be completed?*** September 18, 2014	
K010147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a patient care area but could affect maintenance staff. Findings include: Based on observation and interview with the Administrator and the Maintenance Supervisor on 09/11/14 at 12:00 p.m., he acknowledged a refrigerator was plugged	K010147	K147 ***1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice?*** Refrigerator was unplugged from the power strip until new outlet is installed. ***2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** Other residents that could be affected by the same deficient practice would be identified as those refrigerator plugged into a power strip. None were identified and maintenance door is always	09/26/2014

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	into an extension cord power strip in the Maintenance office. 3.1-19(b)		locked. ***3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** Refrigerator will remain unplugged until new outlet is Installed. ***4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?*** Information gathered from the audits will be forwarded to the QA committee for recommendations and review monthly for two months, then quarterly thereafter. QA committee will recommend time frame for continuing monitoring. ***5. By what date the systemic changes will be completed?*** September 26, 2014	